Enrollment Policy for Physicians

Providers (in-state and out-of-state) who meet enrollment requirements are eligible to participate in the Alabama Medicaid Program. The PA or CRNP must send a copy of the prescriptive authority granted by the licensing board in order for the PA or CRNP to be added to the Provider License File for the purpose of reimbursing the pharmacist for the prescriptions written by the PA or CRNP. This copy must be sent to EDS Provider Enrollment, P.O. Box 244035, Montgomery, AL 36124.

EDS will not enroll physicians having limited licenses unless complete information as to the limitations and reasons are submitted in writing to the Provider Enrollment Unit for review and consideration for enrollment.

28.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Physicians are expected to render medically necessary services to Medicaid patients in the same manner and under the same standards as for their private patients, and bill the Alabama Medicaid Agency their usual and customary fee.

A physician enrolled in and providing services through an approved residency training program will be assigned a pseudo Medicaid license number, but may not bill for services performed as part of the residency training program. A pseudo Medicaid license number is required on written prescriptions issued to Medicaid recipients.

Supervising physicians may bill for services rendered to Medicaid recipients by residents enrolled in and providing services through (as part of) an approved residency training program. The following rules shall apply to physicians supervising residents as part of an approved residency training program:

a. The supervising physician shall sign and date the admission history and physical progress notes written by the resident.

b. The supervising physician shall review all treatment plans and medication orders written by the resident.

c. The supervising physician shall be available by phone or pager.

d. The supervising physician shall designate another physician to supervise the resident in his/her absence.

e. The supervising physician shall not delegate a task to the resident when regulations specify that the physician perform it personally or when such delegation is prohibited by state law or the facility's policy.

Payments from Medicaid funds can be made only to physicians who provide the services; therefore, no reimbursement can be made to patients who may personally pay for the service rendered.

Reimbursement may be made to a physician submitting a claim for services furnished by another physician in the event there is a reciprocal arrangement as long as block 19 on the claim identifies the physician who actually furnished the service. Both physicians should be enrolled as Medicaid providers. The reciprocal arrangement may not exceed 14 days in the case of an informal arrangement or 90 continuous days in the case of an arrangement involving per diem or other fee-for-time compensation. Providers participating in a reciprocal arrangement should be enrolled with the Alabama Medicaid Agency.

The physician agrees when billing Medicaid for a service that the physician will accept as payment in full, the amount paid by Medicaid for that service, plus any cost-sharing amount to be paid by the recipient, and that no additional charge will be made. Conditional collections from patients, made before Medicaid pays, which are to be refunded after Medicaid pays, are not permissible. The physician may bill the patient, in addition to the cost-sharing fee, for services rendered when benefit limitations are exhausted for the year or when the service is a Medicaid non-covered benefit. If a provider routinely accepts a Medicaid assignment, he or she may not bill Medicaid or the recipient for a service he or she did not provide, i.e., missed or canceled appointment.

A hospital-based physician-employed by and paid by a hospital may not bill Medicaid for services performed for which the hospital is reimbursed. A hospital-based physician who is not employed by and paid by a hospital may bill Medicaid using a HCFA-1500 claim form.

A physician enrolled in a residency training program and whose practice is limited to the institution in which that resident is placed shall not bill Medicaid for services performed therein for which the institution is reimbursed through the hospitals' cost reports. For tracking purposes, these physicians will be assigned pseudo Medicaid license numbers.

Hospital-based physicians are reimbursed under the same general system as is used in Medicare. Bills for services rendered are submitted as follows:

- All hospital-based physicians, including emergency room physicians, radiologists, and pathologists, will bill Medicaid on a HCFA-1500 claim form, or assign their billing rights to the hospital, which shall bill Medicaid on a HCFA-1500 claim form.
- Physician services personally rendered for individual patients will be paid only on a reasonable charge basis (i.e., claims submitted under an individual provider number on a physician claim form). This includes services provided by a radiologist and/or pathologist.
- Reasonable charge services are: 1) personally furnished for a patient by a physician; 2) ordinarily require performance by a physician and; 3) contribute to the diagnosis or treatment of an individual patient.

NOTE:

If a provider routinely accepts Medicaid assignments, he/she may not bill Medicaid or the recipient for a service he/she did not provide, i.e., "no call" or "no show".

28.2.1 Physician-Employed Practitioner Services

Medicaid payment may be made for the professional services of the following physician-employed practitioners:

- Physician Assistants (PAs)
- Certified Registered Nurse Practitioners (CRNPs)

Nurse Practitioner is defined as a Registered Professional Nurse who is currently licensed to practice in the state, who meets the applicable State of Alabama requirements governing the qualifications of nurse practitioners.

Physician Assistant means a person who meets the applicable State of Alabama requirements governing the qualifications for assistants to primary care physicians.

Medicaid will make payment for services of Physician Assistants (PAs) and Certified Registered Nurse Practitioners (CRNPs) who are legally authorized to furnish services and who render the services under the supervision of an employing physician with

payment made to the employing physician. Medicaid will not make payment to the PA or CRNP. Generally, CRNPs and PAs are reimbursed at 80% of the allowed amount for all services except lab and injectables, which should pay at 100%.

The employing physician must be a Medicaid provider in active status.

The PA or CRNP must enroll with Medicaid and receive an Alabama Medicaid provider number with the employing physician as the payee.

Covered services furnished by the PA or CRNP must be billed under the PA's or CRNP's name and Alabama Medicaid provider number.

The covered services for PAs and CRNPs are limited to injectable drugs, laboratory services in which the laboratory is CLIA certified to perform, and the CPT codes identified in Appendix O, CRNP & PA Services.

The office visits performed by the PA or CRNP count against the recipient's yearly benefit limitation.

The PA or CRNP may make physician-required visits to nursing facilities.

The PA or CRNP may not make physician-required visits to hospitals or other institutional settings to qualify for payment to the physician or to satisfy current regulations as physician visits.

The PA or CRNP may provide low complexity or straightforward medical decision-making services in the emergency room or as an assistant at surgery for reimbursement by Medicaid. See Appendix O for a list of covered services.

The employing-physician need not be physically present with the PA or CRNP when the services are being rendered to the recipient; however, the physician must be immediately available to the PA or CRNP for direct communication by radio, telephone, or telecommunication.

The PA's or CRNP's employing physician is responsible for the professional activities of the PA or CRNP and for assuring that the services provided are medically necessary and appropriate for the patient.

There shall be no independent, unsupervised practice by PAs or CRNPs.

28.2.2 Covered Services

In general, Medicaid covers physician services if the services meet the following conditions:

- Considered medically necessary by the attending physician
- Designated by procedure codes in the Physicians' Current Procedural Terminology (CPT), HCPCS or designated by special procedure codes created by Medicaid for its own use

This table contains details on selected covered services.

Service	***Coverage and Conditions***
Anesthesia	Anesthesia is covered. See Chapter 38, Anesthesiology.
Artificial Eyes	Artificial eyes must be prescribed by a physician.
Computerized Axial Tomograph (CAT) Scans	CAT scans are covered as medically necessary.
Chiropractors	Chiropractic services are covered only for QMB recipients and for services referred directly as a result of an EPSDT screening.
Chromosomal Studies	Medicaid can pay for these studies on prospective mothers in an effort to identify conditions that could result in the birth of an abnormal child.

Service	***Coverage and Conditions***
Circumcision	Circumcision of newborns is a covered service. If medically necessary, non-newborn circumcision is covered.
Diet Instruction	Diet instruction performed by a physician is considered part of a routine visit.
Drugs	Non-injectable drugs must be billed by a pharmacy to be covered. Physicians who administer injectable drugs to their patients may bill Medicaid for the cost of the drug by using the procedure code designated by Medicaid for this purpose.
Examinations	Physician visits for examinations are counted as part of each recipient's benefit limit of 14 physician visits per year. Exception: Certified Emergencies. Annual routine physical examinations are not covered except through EPSDT. Refer to Appendix A, EPSDT, for details. Medical examinations for such reasons as insurance policy qualifications are not covered. Physical examinations for establishment of total and permanent disability status if considered medically necessary are covered. Medicaid requires a physician's visit once every 60 days for patients in a nursing facility. Patients in intermediate care facilities for the mentally retarded must receive a complete physical examination at least annually.
Eyecare	Eye examinations by physicians are a Medicaid covered service. Physician visits for eyecare disease are counted as part of each recipient's benefit limit of 14 physician visits per year.
Foot Devices	See Chapter 14, Durable Medical Equipment (DME), for details
Gastric bypass	Covered with prior authorization
Hearing Aids	See Chapter 10, Audiology/Hearing Services, for details.
Immunizations	The Department of Public Health provides vaccines at no charge to Medicaid physicians enrolled in the Vaccines For Children (VFC) Program. Medicaid reimburses administration fees for vaccines provided free of charge through the Vaccines For Children (VFC) Program. Medicaid tracks usage of the vaccine through billing of the administration fee using the appropriate CPT-4 codes. Refer to Appendix A, EPSDT, for more information. The single antigen vaccines may be billed only when medically justified and prior authorized. These vaccines are listed below: • Diphtheria • Measles • Mumps • Rubella Payment for immunizations against communicable diseases for adults will be made if the physician normally charges his patients for this service.
Infant Resuscitation	Newborn resuscitation (procedure code 99440) is a covered service when the baby's condition is life threatening and immediate resuscitation is necessary to restore and maintain life functions. Intubation, endotracheal, emergency procedure (procedure code 31500) cannot be billed in conjunction with newborn resuscitation.
Medical Materials and Supplies	Costs for medical materials and supplies normally utilized during office visits or surgical procedures are to be considered part of the total fee for procedures performed by the physician and therefore are not generally a separately billable service.
Newborn Claims	Five kinds of newborn care performed by physicians in the days after the child's birth when the mother is still in the hospital may be filed under the mother's name and number or the baby's name and number: 1. Routine newborn care (99431, 99433, and discharge codes 99238 or 99239) 2. Circumcision (54150 or 54160) 3. Newborn resuscitation (99440) 4. Standby services following a caesarian section or a high-risk vaginal delivery. (99360) 5. Attendance at delivery (when requested by delivering physician) and initial stabilization of newborn (99436) Standby services (procedure code 99360) are covered only when the pediatrician, family practitioner, neonatologist, general practitioner, or non-delivering OB/GYN is on standby in the operating or delivery room during a caesarian section or a high-risk vaginal delivery. Attendance of the standby physician in the hospital operating or delivery room must be documented in the operating or delivery report.

Service	*Coverage and Conditions*
	Use CPT codes when filing claims for these five kinds of care. If these services are billed under the mother's name and number and the infant(s) are twins, indicate Twin A or Twin B in Block 19 of the claim form. Any care other than routine newborn care for a well baby, before and after the mother leaves the hospital, must be billed under the child's name and number.
Newborn Hearing Screening	Inpatient newborn hearing screenings are considered an integral part of inpatient hospital services. Newborn hearing screenings are limited to EENT, otolaryngologist, pediatrician and audiologist specialties.
Obstetrical Services	Refer to Section 28.2.10
Oxygen and Compressed Gas	A physician's fee for administering oxygen or other compressed gas is a covered service under the Medicaid program. Oxygen therapy is a covered service based on medical necessity and requires prior authorization. Please refer to Chapter 14, DME, for more information.
Podiatrist Service	Covered for QMB or EPSDT referred services only. See Chapter 29, Podiatrist, for more details.
Post Surgical Visits	Post-surgical hospital or office visits for conditions directly related to major surgical procedures are covered by the surgical fee. Post-surgical visits cannot be billed separately the day of, or up to 62 days after surgery.
Prosthetic Devices	Internal prosthetic devices (e.g., Smith Peterson Nail or pacemaker) are a covered benefit.
Psychiatric Services	Physician visits for psychiatric services are counted as part of each recipient's benefit limit of 14 physician visits per year. Psychiatric evaluation or testing are covered services under the Physicians' Program if services are rendered by a physician in person and are medically necessary. Psychiatric evaluations are limited to one per calendar year, per provider, per recipient. Psychotherapy visits are included in the office visit limit of 14 visits per calendar year. Office visits are not covered when billed in conjunction with psychotherapy codes. Psychiatric services under the Physicians' Program are confined to use with psychiatric diagnosis (290-319) and must be performed by a physician. Hospital visits are not covered when billed in conjunction with psychiatric therapy on the same day. For services rendered by psychologist, see Appendix A, EPSDT, for details. Psychiatric day care is not a covered benefit under the Physicians' Program.
Second Opinions	Physician visits for second opinions are counted as part of each recipient's benefit limit of 14 physician visits per year. Optional Surgery: Second opinions (regarding non-emergency surgery) are highly recommended in the Medicaid program when the recipients request them. Diagnostic Services: Payment may be made for covered diagnostic services deemed necessary by the second physician.
Self-inflicted injuries	Self-inflicted injuries are covered.
Surgery	Cosmetic surgery is covered only when prior approved for medical necessity. Examples of medical necessity include prompt repair of accidental injuries or improvement of the functioning of a malformed body member. Elective surgery is covered when medically necessary. Multiple surgeries are governed by the following rules: When multiple or bilateral surgical procedures that add significant time or complexity are performed at the same operative session, through the same incision or separate incisions in the same operative field, Medicaid pays for the procedure with the highest allowed amount and half of the allowed amount for each subsequent procedure. This also applies to laser surgical procedures. Additional payments will not be made for procedures considered to be mutually exclusive or incidental. Certain procedures are commonly carried out as integral parts of a total service and as such do not warrant a separate charge. When incidental procedures (e.g., excision of a previous scar or puncture of an ovarian cyst) are performed during the same operative session, Medicaid reimburses for the major procedure only. Laparotomy is covered when it is the only surgical procedure performed during the operative session or when performed with an unrelated or incidental surgical procedure.

Service	***Coverage and Conditions***
Surgery, Breast Reconstruction	Breast reconstruction surgery is reimbursable following a medically necessary mastectomy when performed for the removal of cancer. All reconstructive procedures require prior authorization. The term "reconstruction" shall include augmentation mammoplasty, reduction mammoplasty, and mastoplexy. Breast reconstruction surgeries are governed by the following rules: • The reconstruction follows a medically necessary mastectomy for the removal of cancer • The recipient is eligible for Medicaid on the date of reconstruction surgery • The recipient elects reconstruction within two years of the mastectomy surgery • The diagnosis codes used are appropriate • The surgery is performed in the manner chosen by the patient and the physician in accordance with guidelines consistent with Medicare and other third party payers • For more information regarding prior authorization, please refer to Chapter 4 Obtaining Prior Authorization. For more information related to breast prosthesis, please refer to Chapter 14 Durable Medical Equipment.
Therapy	Physician visits for therapy are counted as part of each recipient's benefit limit of 14 physician visits per year. See Rule No. 560-X-6-.14 for details about this benefit limit in the *Alabama Medicaid Agency Administrative Code,* Chapter 6. Physical Therapy is not covered when provided in a physician's office. Physical therapy is covered only when prescribed by a physician and provided in a hospital setting. Refer to Chapter 19, Hospital, for more information. Group Therapy is a covered service when a psychiatric diagnosis is present and the therapy is prescribed, performed, and billed by the physician personally. Group Therapy is not covered when performed by a caseworker, social services worker, mental health worker, or any counseling professional other than physician. Group Therapy is included in the physician visit limit of 14 visits per year. Speech Therapy for a speech related diagnosis, such as stroke (CVA) or partial laryngectomy, is a covered benefit when prescribed by and performed by a physician in his office. Speech therapy performed in an inpatient or outpatient hospital setting or in a nursing facility is a covered benefit, but is considered covered as part of the reimbursement made to the facility and should not be billed by the physician. Family Therapy is a covered service when a psychiatric diagnosis is present and the physician providing the service supplies documentation that justifies the medical necessity of the therapy for each family member. Family therapy is not covered unless the patient is present. Family Therapy is not covered when performed by a caseworker, social service worker, mental health worker, or any counseling professional other than a physician. Family Therapy is included in the physician visit limit of 14 visits per year.
Transplants	See Chapter 19, Hospitals, for transplant coverage.
Ventilation Study	Ventilation study is covered if done in physician's office by the physician or under the physician's direct supervision. Documentation in the medical record must contain all of the following: • Graphic record • Total and timed vital capacity • Maximum breathing capacity Always indicate if the studies were performed with or without a bronchodilator.
Well Baby Coverage	Well baby coverage is covered only on the initial visit, which must be provided within eight weeks of the birth. When the well-baby checkup is done, the physician should bill procedure code 99432. Only one well-baby checkup can be paid per lifetime, per recipient. Refer to Appendix A, EPSDT, for information on additional preventive services.

NOTE:

The Agency recognizes the current CPT definition for starred (*) procedures or items.

28.2.3 Non-covered Services

Service	*Coverage and Conditions*
Acupuncture	Acupuncture is not covered.
After Office Hours	The following services are not covered: After office hours, services provided in a location other than the physician's office, and office services provided on an emergency basis.
Autopsies	Autopsies are not covered.
Biofeedback	Biofeedback is not covered.
Blood Tests	Blood tests are not covered for marriage licenses.
Chiropractors	Chiropractic services are not covered, except for QMB recipients and for services referred directly as a result of an EPSDT screening.
Chromosomal Studies	Chromosomal studies (amniocentesis) on unborn children being considered for adoption are not covered. Medicaid can pay for these studies on prospective mothers in an effort to identify conditions that could result in the birth of an abnormal child.
Experimental Treatment or Surgery	Experimental treatment or surgery is not covered.
Filing Fees	Filing Fees are not covered.
Hypnosis	Hypnosis is not covered.
Laetrile Therapy	Laetrile therapy is not covered.
Oxygen and Compressed Gas	A physician's fee for administering oxygen or other compressed gas is a covered service under the Medicaid program; the cost of the oxygen or gas is not covered.
Post Surgical Visits	Post-surgical hospital or office visits for conditions directly related to major surgical procedures are covered by the surgical fee. Post-surgical visits cannot be billed separately one day prior to surgery or up to 62 days after surgery. Visits by Assistant Surgeon or Surgeons are not covered.
Preventive Medicine	Medicaid does not cover preventive medicine other than those specified elsewhere, including but not limited to, EPSDT screening.
Syntocin	Syntocin is not covered.
Telephone Consultations	Telephone consultations are not covered.
Therapy	Occupational and Recreational Therapies are not covered.

28.2.4 Limitations on Services

Within each calendar year each recipient is limited to no more than a total of 14 physician visits in offices, hospital outpatient settings, nursing facilities, rural health clinics or Federally Qualified Health Centers. Visits not counted under this benefit limit will include, but not be limited to, visits for: EPSDT, prenatal care, postnatal care, and family planning. Physicians services provided in a hospital outpatient setting that have been certified as an emergency do not count against the physician benefit limit of 14 per calendar year. If a patient receives ancillary services in a doctor's office, by the physician or under his/her direct supervision, and the doctor submits a claim only for the ancillary services but not for the office visit, then the services provided will not be counted as a visit.

For further information regarding outpatient maintenance dialysis and ESRD, refer to Chapter 35, Renal Dialysis Facility.

A new patient office visit codes shall not be paid to the same physician or same group practice for a recipient more than once in a three-year period.

28.2.5 Physician Services to Hospital Inpatients

In addition to the 14 physician visits, Medicaid covers up to 16 inpatient dates of service per physician, per recipient, per calendar year. For purposes of this limitation, each specialty within a group or partnership is considered a single provider.

When filing claims for recipients enrolled in the Patient 1st Program, Chapter 39, Patient 1st, to determine whether your services require a referral from the Primary Medical Provider (PMP).

Physician hospital visits are limited to one visit per day, per recipient, per provider.

Any physician billing for a professional interpretation for an inpatient may not bill for a hospital visit on the same inpatient day for the same recipient. Medicaid will cover either one hospital visit or professional interpretation(s) up to the allowed benefit limit.

Professional interpretations for lab and x-ray (CPT code 70000 through 80000 services) in the inpatient setting can only be billed by pathologists and radiologists. The only exception is for professional interpretations by cardiologists for catheterization or arterial studies and for select laboratory procedures by oncologists and hematologists. Professional interpretations done by other physicians for services in this procedure code range are included in the hospital visit if one is done. If no hospital visit is made, professional interpretation by physicians other than radiologists, pathologists, oncologists, hematologists, and cardiologists should not be billed as these services are covered only for the above-mentioned specialties.

A physician hospital visit and hospital discharge shall not be paid to the same physician on the same day. If both are billed, only the discharge shall be paid.

An office visit and an inpatient visit shall not be paid to the same physician on the same day. If both are billed, then the first Procedure Code billed will be paid.

28.2.6 Critical Care

When caring for a critically ill patient in which the constant attention of the physician is required, the appropriate critical care procedure code (99291 and 99292) must be billed. Critical care is considered a daily global inclusive of all services directly related to critical care.

Coverage of critical care may total no more than four hours per day.

The actual time period spent in attendance at the patient's bedside or performing duties specifically related to that patient, irrespective of breaks in attendance, must be documented in the patient's medical record.

No individual procedures related to critical care may be billed in addition to procedure codes 99291 and 99292, except those procedures listed below:

- Procedure code 99360 and either procedure code 99221, 99222, or 99223 (initial hospital care) may be billed once with each hospital stay and may be billed with critical care.
- An EPSDT screening may be billed in lieu of the initial hospital care (P/C 99221, 99222, or 99223). If screening is billed, the initial hospital care can not be billed.
- Procedure code 99082 (transportation or escort of patient), may also be billed with critical care (99291 and/or 99292). Only the attending physician may bill this service and critical care. Residents or nurses who escort a patient may not bill either service.